

**Rules of
 Department of Social Services
 Division 70—Division of Medical Services
 Chapter 95—Private Duty Nursing Care Under the
 Healthy Children and Youth Program**

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Title 13—DEPARTMENT OF SOCIAL SERVICES

Division 70—Division of Medical Services

Chapter 95—Private Duty Nursing Care Under the Healthy Children and Youth Program

13 CSR 70-95.010 Private Duty Nursing

PURPOSE: This rule establishes the basis for Medicaid enrollment and reimbursement of providers of private duty nursing care for children under Missouri's Healthy Children and Youth Program.

Editor's Note: The secretary of state has determined that the publication of this rule in its entirety would be unduly cumbersome or expensive. The entire text of the material referenced has been filed with the secretary of state. This material may be found at the Office of the Secretary of State or at the headquarters of the agency and is available to any interested person at a cost established by state law.

(1) Service Definition. Private duty nursing is the provision of individual and continuous care (in contrast to part-time or intermittent care) provided according to an individual plan of care approved by a physician, by licensed nurses acting within the scope of the Missouri Nurse Practice Act. Services within the Medicaid private duty nursing program include:

(A) Shift care by a registered nurse (RN); and

(B) Shift care by a licensed practical nurse (LPN).

(2) Persons Eligible for Private Duty Nursing Care. Medicaid-eligible children under the age of twenty-one (21) may be eligible for private duty nursing care under the Healthy Children and Youth Program (HCY) when there is a medical need for a constant level of care, exceeding the family's ability to independently care for the child at home on a long-term basis without the assistance of at least a four (4)-hour shift of home nursing care per day. Private duty nursing services for children are prior authorized by the Bureau of Special Health Care Needs of the Department of Health.

(3) Criteria for Providers of Private Duty Nursing Care for Children.

(A) A provider of private duty nursing care must have a valid Medicaid Private Duty Nursing Provider Agreement in effect with the Department of Social Services, Division of Medical Services. To enroll, the applicant must either submit a written proposal, or be a

Medicare-certified and Medicaid-enrolled home health agency, or be accredited by Joint Commission for Accreditation of Health Organization (JCAHO), or be accredited by Community Health Accreditation Program (CHAPS). The written proposal (required by agencies who are not Medicare certified, or accredited by JCAHO or CHAPS), must describe the agency and its service delivery system, assure understanding of and compliance with the standards of the Private Duty Nursing Care Program and document the agency's administrative and fiscal ability to provide the services in accordance with these standards. Proposals will be reviewed by qualified medical staff or designees of the Department of Social Services (DSS).

(B) All applicants to provide Medicaid private duty nursing care, enrolling on the basis of a written proposal, may be subject to on-site reviews, performed at the discretion of the department, by DSS staff or designees prior to enrollment. These reviews will monitor compliance with the administrative requirements of the program and service delivery.

(C) On-site reviews to monitor compliance with these standards will be conducted at the discretion of the department subsequent to Medicaid enrollment, when Medicaid has reimbursed for services.

(D) Agencies found to be out of compliance with the standards set forth in this rule may have a penalty imposed. Penalties may be as follows:

1. The agency will be required to submit a written plan of correction, with a follow-up monitoring by DSS staff within ninety (90) days;

2. New prior authorization requests will not be approved for a specified period of time; and

3. The Medicaid provider enrollment agreement will be terminated.

(4) Administrative Requirements for Private Duty Providers.

(A) The provider shall immediately notify the provider enrollment unit of the Division of Medical Services of any change in location, telephone number, administrative or corporate status. A thirty (30)-day written notice to the Division of Medical Services will be required of the provider prior to the voluntary termination of the provider agreement.

(B) The provider shall maintain bonding, personal and property liability, and medical malpractice insurance coverage on all employees involved in delivering nurse service in the home.

(C) The provider must have the capability to provide nursing staff outside of regular business hours, on weekends and on holidays to provide services in accordance with the plan

of care authorized by the Bureau of Special Health Care Needs for each client.

(D) The provider must have a policy for responding to emergency situations. Services reimbursed by Medicaid may not exceed the prior authorization approved by the Bureau of Special Health Care Needs, therefore, any emergency situation resulting in service delivery beyond the limits of the prior authorization must be reported in writing to the Bureau of Special Health Care Needs within seventy-two (72) hours.

(E) The provider shall have a written statement of the recipient's Bill of Rights, which shall be given to the caretaker (if the recipient is a minor) at the time the service is initiated. At a minimum, the statement should say that the recipient has the right to the following:

A. Be treated with respect and dignity;

B. Have all personal and medical information kept confidential;

C. Have direction over the services provided, to the degree possible, within the service plan approved by the Bureau of Special Health Care Needs;

D. Know the provider's established grievance procedure and how to make a complaint about the service and receive cooperation to reach a resolution, without fear of retribution;

E. Receive services without regard to race, creed, color, age, sex or national origin; and

F. Receive a copy of this Bill of Rights.

(F) The provider shall have a written grievance policy which shall be provided to each recipient or caretaker upon initiation of services. The grievance policy must also include the phone number of the Bureau of Special Health Care Needs and the Division of Medical Services, recipient services unit.

(G) The provider must report all instances of possible child abuse or neglect to the Child Abuse and Neglect (CA/N) Hotline, 1-800-392-3738. Any suspected abuse or neglect by a caretaker, including private duty nursing staff, must be reported according to 210.110—210.189, RSMo, the Child Abuse Law. Failure to report by a mandatory reporter (private duty nursing staff would be considered mandatory reporters) is a violation of 210.115, RSMo and could be subject to prosecution.

(H) The provider must maintain Missouri Corporate Good Standing status with the Office of the Missouri Secretary of State.

(5) Qualification Requirements for Private Duty Nursing Direct Care Staff and Supervisors.

(A) For nursing staff, the provider agency shall show evidence in the personnel record that the employee's licensure status with the Missouri Board of Nursing is current.

(B) Upon initial employment, the provider shall document that at least two (2) employment or personal references (not to include relatives) were contacted prior to that employee delivering direct care services.

(C) The provider will be responsible for assuring and documenting that the nurse's health permits performance of the required activities and does not pose a health hazard. Service delivery shall be prohibited when the employee has a communicable condition. Before contact with clients, all employees who will be delivering services in the home must pass a health assessment or physical examination, including tuberculosis (TB) testing, conducted by a physician or a nurse. Self assessment will not be accepted for LPN and RN staff. Health assessments or physical exams shall be repeated at two (2)-year intervals and the results shall be maintained on-site by the provider. Annual TB testing is required, with documentation to be maintained by the provider.

(6) Requirements for Training for Private Duty Staff.

(A) All direct care staff (LPNs and RNs) must have at least four (4) hours of orientation training prior to service provision. Orientation training should include general information about the Medicaid Private Duty Nursing Program, the HCY program, relationship of the provider agency with the Division of Medical Services and the Bureau of Special Health Care Needs, the prior authorization process, child abuse/neglect indicators and reporting, recipient rights, recipient grievance procedures, internal agency policy and a review of universal precaution procedures as defined by the Center for Disease Control.

(B) Prior to delivering services for the first time for each child they are assigned to care for, LPNs must demonstrate competency in each task required by the plan of care. The competency demonstration must be conducted by an RN and must be documented in the LPN's personnel file.

(C) All direct care staff must have certification in either cardiopulmonary resuscitation (CPR) or basic certified life-support (BCL).

(7) Requirements for Supervision of Private Duty Nursing Staff.

(A) Each agency shall employ an RN, with three (3) years' experience, to act as supervisor to all other nursing staff. One (1) year of experience must either be in supervisory position or in the field of pediatric nursing. The RN supervisor will be responsible for case

conferences with staff nurses and documenting the conferences, assuring the competency of staff, training and orientation and evaluation of direct care staff.

(B) All nursing staff providing direct care shall have an annual performance evaluation completed by an RN supervisor, maintained in the personnel record. The evaluation must be based on a minimum of two (2) on-site visits with the staff person present.

(C) Frequency of Supervisory Visits.

1. Recipients of private duty nursing care shall have a personal visit by a supervisory RN at least once every sixty (60) days if the recipient is authorized for LPN service. Supervisory visits by an RN will not be separately reimbursed.

2. Patients who have received RN shift care through the Private Duty Nurse Program or intermittent visits by an RN under the home health program (if those services were provided by an agency affiliated with the private duty provider) are not required to have a separate supervisory visit.

3. Supervisory visits, or explanation of why there are no separate supervisory visits for the month (that is, RN shifts were delivered) are to be documented in the recipient record.

(8) Requirements for the Contents of Medical Records. Appropriate medical records for each Medicaid recipient served must be maintained at the private duty nursing agency. Records should be kept confidential and access should be limited to private duty nursing staff and representatives of the Departments of Social Services and Health.

(A) Medical records shall contain the following:

1. Identifying information about the recipient, such as name, birthdate, Medicaid number, caretaker and emergency contact person;

2. All forms or correspondence to and from the Bureau of Special Health Care Needs regarding the services which have been prior authorized;

3. Signed physician orders prior to service delivery which must be updated each time the prior authorization is due for approval by the Bureau of Special Health Care Needs;

4. Consent from the child's legal custodian for treatment prior to service delivery;

5. The plan of care, documenting the amount, duration and scope of the service. The level of care indicated in the plan of care (RN or LPN) must be based on acceptable standards of nursing practice. Reimbursement is based on the prior authorization approved by the Bureau of Special Health Care Needs, with that prior authorization based upon the plan of care, specifying the number of hours and the

skill level of the service, for periods of up to six (6) months;

6. Weekly documentation of all services provided and any supervisory visits;

7. Documentation of the LPN's competency demonstration before an RN when the plan of care includes the services of an LPN as required in subsection (6)(C); and

8. Documentation that a copy of the recipient's Bill of Rights was given to the recipient, parent or guardian.

(9) Reimbursement.

(A) Payment will be made in accordance with the fee per unit of service as defined and determined by the Division of Medical Services.

1. A unit of service is one (1) hour.

2. A separate fee per unit of service will be established for the services of the RN or LPN.

3. The fee per unit of service will be based on the determination by the state agency of the reasonable cost of providing the covered services on a statewide basis and within the mandatory maximum payment limitations.

4. Payment will be made on the lower of the established rate per service unit or the provider's billed charges. The charge billed to Medicaid may not be more than a provider's ordinary charge to the general public for the same services.

(B) Conditions for Reimbursement.

1. Services will be authorized by the Bureau of Special Health Care Needs prior to delivery, in accordance with a private duty nursing care plan, specifying the amount, duration and scope of services. The prior authorization will be the basis for reimbursement.

(10) *Medicaid Private Duty Nursing Provider Manual*. A private duty nursing provider manual shall be produced by the Division of Medical Services and shall be distributed to all private duty nursing providers participating in the Missouri Medicaid Program. The manual shall contain information about Medicaid eligibility, third party liability, procedures for requesting prior authorization, claim filing instructions, instructions for filing adjustments, reimbursement methodology and current Medicaid maximum rates of reimbursement for services, benefits and limitations of services and other applicable information about the program.

*Auth: sections 208.152, RSMo (Cum. Supp. 1993), 208.153, RSMo (Cum. Supp. 1991) and 208.201, RSMo (Supp. 1987).**
Original rule filed Sept. 2, 1993, effective April 9, 1994. Amended: Filed April 4, 1994, effective Oct. 30, 1994.

**Original authority: 208.152, RSMo (1967), amended 1969, 1971, 1972, 1973, 1975, 1977, 1978, 1981, 1986, 1988, 1990, 1992, 1993; 208.153, RSMo (1967), amended 1973, 1989, 1990, 1991; and 208.201, RSMo (1987).*

CSR



MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
PRIOR AUTHORIZATION REQUEST

RETURN TO:
GTE DATA SERVICES
P.O. BOX 5700
JEFFERSON CITY, MO
65102

Authorization approves the medical necessity of the requested service only. It does not guarantee payment, nor does it guarantee that the amount billed will be the amount reimbursed. The recipient must be Medicaid Eligible on the date of service or date the equipment or prosthesis is received by the recipient. **SEE REVERSE SIDE FOR INSTRUCTIONS.**

I. GENERAL INFORMATION

1. <input type="checkbox"/> INITIAL <input type="checkbox"/> CHANGE		PA #	2. NAME (LAST, FIRST, M.I.)		3. DATE OF BIRTH
4. ADDRESS (STREET, CITY, STATE, ZIP CODE)				5. MEDICAID NUMBER	
6. PROGNOSIS		7. DIAGNOSIS CODE	8. DIAGNOSIS DESCRIPTION		
9. NAME AND ADDRESS OF FACILITY WHERE SERVICES ARE TO BE RENDERED IF OTHER THAN HOME OR OFFICE.					

II. HCY (EPSDT) SERVICE REQUEST (MAY REQUIRE PLAN OF CARE)

10. DATE OF HCY SCREEN	11. SCREENING <input type="checkbox"/> FULL <input type="checkbox"/> INTERPERIODIC <input type="checkbox"/> PARTIAL		12. TYPE OF PARTIAL HCY SCREEN		
13. SCREENING PROVIDER NAME		14. PROVIDER NUMBER		15. TELEPHONE NUMBER ()	

III. SERVICE INFORMATION (DO NOT WRITE IN SHADED AREAS) FOR STATE USE ONLY

16. REF. NO.	17. TYPE SERV.	18. PROCEDURE CODE	19. FROM	20. THROUGH	21. DESCRIPTION OF SERVICE/ITEM	22. QTY. OR UNITS	23. AMOUNT TO BE CHARGED	APPR.	DENIED	AMOUNT ALLOWED IF PRICED BY REPORT
(1)										
(2)										
(3)										
(4)										
(5)										
(6)										
(7)										
(8)										

24. DETAILED EXPLANATION OF MEDICAL NECESSITY FOR SERVICES/EQUIPMENT/PROCEDURE/PROSTHESIS (ATTACH ADDITIONAL PAGES IF NECESSARY)

IV. PROVIDER		V. PRESCRIBING/PERFORMING PRACTITIONER	
25. PROVIDER NAME (AFFIX LABEL HERE)		29. NAME	30. TELEPHONE ()
26. ADDRESS		31. ADDRESS	
27. MEDICAID PROVIDER NUMBER		32. DATE DISABILITY BEGAN	33. PERIOD OF MEDICAL NEED IN MONTHS
28. SIGNATURE		I certify that the information given in Sections I and III of this form is true, accurate, and complete.	
DATE		34. SIGNATURE OF PRESCRIBING PHYSICIAN/PRACTITIONER	DATE

VI. FOR STATE OFFICE USE ONLY

DENIAL REASONS(S): REFER FIELD 16 ABOVE BY REFERENCE NUMBERS (REF. NO.)

IF APPROVED: services authorized to begin	DATE	REVIEWED BY SIGNATURE ►
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THIS FORM IS TO BE USED FOR EPSDT (HCY) RELATED SERVICES ONLY

FIELD NUMBER AND NAME - INSTRUCTIONS FOR COMPLETION

I. GENERAL INFORMATION - To be completed by the provider requesting the prior authorization.

1. Transaction Type - Check INITIAL or CHANGE. If change, enter initial prior authorization (PA) number.
2. Recipient's Name - Enter the recipient's name as it appears on the Medicaid ID card. Enter the recipient's current address.
3. Date of Birth - Enter the recipient's date of birth.
4. Address - Enter the recipient's address, city, state, and zip.
5. Medicaid Number - Enter the recipient's 8-digit Medicaid identification number as shown on the Medicaid identification card or county letter of eligibility.
6. Prognosis - Enter the recipient's prognosis.
7. Diagnosis Code - Enter the diagnosis code(s).
8. Diagnosis Description - Enter the diagnosis description. If there is more than one diagnosis, enter all descriptions appropriate to the services being requested.
9. Name and address of the facility where services are to be rendered if service is to be provided other than home or office.

II. HCY SERVICE REQUEST (Plan of care may be required, see your provider manual)

10. Date of HCY Screen - Enter the date the HCY Screen was done.
11. Screening - Check whether the screening performed was FULL, INTERPERIODIC, or PARTIAL.
12. Type of Partial HCY Screen - Enter the type of partial HCY Screen that was performed. (e.g., Vision, Hearing, etc.)
13. Screening Provider Name - Enter the provider's name who performed the screening.
14. Provider Number - Enter the provider's number who performed the screening.
15. Telephone Number - Enter the screening provider's telephone number including the area code.

III. SERVICE INFORMATION

16. Ref. No. - (Reference Number) A unique designator (1-8) identifying each separate line on the request.
17. Type of Service - Enter the appropriate type of service code for each procedure code.
18. Procedure Code - Enter the procedure code(s) for the services being requested.
19. From - Enter the from date that services will begin if authorization is approved (mm/dd/yy format).
20. Through - Enter the through date the services will terminate if authorization is approved (mm/dd/yy format).
21. Description of Service/Item - Enter a specific description of the service/item being requested.
22. Quantity or Units - Enter the quantity or units of service/item being requested.
23. Amount to be Charged - Enter the amount to be charged for the service.
24. Detailed Explanation of Medical Necessity of the service, equipment/procedure/prosthesis, etc. Attach additional page(s) as necessary.
Do not use another Prior Authorization Form.

IV. PROVIDER REQUESTING PRIOR AUTHORIZATION

25. Provider Name - Attach a Medicaid provider label or enter the requested provider's information exactly as it appears on the label.
26. Address - If a Medicaid provider label is not used, enter the complete mailing address in this field.
27. Medicaid Provider Number - If a Medicaid provider label is not used, enter the provider's Medicaid Identification number.
28. Signature/Date - The provider of services should sign the request and indicate the date the form was completed.
(Check your provider manual to determine if this field is required.)

V. PRESCRIBING/PERFORMING PRACTITIONER

This section must be completed for services which require a prescription such as Durable Medical Equipment, Physical Therapy, or for services which will be prescribed by a physician/practitioner that require Prior Authorization. Check your provider manual for additional instructions.

29. Name - Enter the name of the prescribing/performing/practitioner.
30. Telephone Number - Enter the prescribing/performing/practitioner telephone number including area code.
31. Address - Enter the address, city, state, and zip code.
32. Date Disability Began - Enter the date the disability began. For example, if a disability originated at birth, enter date of birth.
33. Period of Medical Need in Months - Enter the estimated number of months the recipient will need the equipment/services.
34. Signature of prescribing/performing/practitioner - The prescribing physician/practitioner must sign and indicate the date signed in mm/dd/yy format. **(Signature stamps are not acceptable)**

VI. FOR STATE OFFICE USE ONLY

Approval or denial for each line will be indicated in the box to the right of Section III. Also in this box the consultant will indicate allowed amount if procedure requires manual pricing.

At the bottom, the consultant may explain denials or make notations referencing the specific procedure code and description by number (1 thru 8). The consultant will sign or initial the form.

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